The following items can be charged to recipients:

(a) Customary room charge to reserve a room during a recipient's hospital stay, therapeutic leave in excess of the maximum allowed, and other absences.
(b) Customary private room differential charge if a private room is not medically necessary.
(c) Private duty nurse or attendants.
(d) Telephone, television, newspaper, and magazines.
(e) Guest meals.
(f) Barber and beauty shop, services other than routine grooming required as part of the patient's care plan.
(g) Personal clothing and laundry.
(h) Personal dental and grooming items.
(i) Tobacco products.
(j) Burial services and items.

Level of Care criteria is described in Appendix 1 of Attachment 3.1-A.
Level of Care criteria for non acute intensive rehabilitation head-injury care described in Appendix 3 of Attachment 3.1-A.
Level of Care criteria for ventilator-dependent care described in Appendix 4 of Attachment 3.1-A.

4.b. Early and Periodic Screening, Diagnosis and Treatment

(1) Prior approval is required for hearing aids. The prior approval request must be supported by a medical evaluation and prescription from an otologist, otolaryngologist, or speech clinic affiliated with the outpatient department of a hospital. An audiogram must be included.

(2) Dental Services

Covers fillings, extractions, restorative services, stainless steel space maintainers, prophylaxes, scaling and curretage, fluoride, x-rays, relief of pain, periodontic services, complete and partial dentures with rebasing and relining, endodontic therapy on anterior teeth, surgery, and orthodontics.

(3) Dentures

Prior approval is required. Completed and partial dentures are allowed only once in a ten (10) year period. Where medical necessity may be a factor, individual consideration may be given. Standard materials and procedures are used for full and partial dentures. Initial reline of dentures may be reimbursed only if six (6) months have elapsed since receipt of dentures. Subsequent relines are allowed only at five (5) year intervals.

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(a) Customary room charge to reserve a room during a recipient's hospital stay, therapeutic leave in excess of the maximum allowed, and other absences.
(b) Customary private room differential charge if a private room is not medically necessary.
(c) Private duty nurse or attendants.
(d) Telephone, television, newspaper, and magazines.
(e) Guest meals.
(f) Barber and beauty shop, services other than routine grooming required as part of the patient's care plan.
(g) Personal clothing and laundry.
(h) Personal dental and grooming items.
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) Medically necessary prosthetic and orthotic devices are covered by the Medicaid program for EPSDT eligible children when prescribed by a physician and supplied by a qualified provider. Prior approval must be obtained from the Division of Medical Assistance, or its designated agent.

To be a qualified provider, an entity must possess a state business license and meet Medicare's certification standards as a supplier of prosthetic or orthotic devices, or be a Medicaid enrolled home health agency, a state agency, a local health department, a local lead agency for the Community Alternatives Program for disabled adults, or for the mentally retarded or developmentally disabled, or a local lead agency that provides case management for the Community Alternative Program for children.

Only items determined to be medically necessary, effective and efficient are covered.

When devices are provided by state or local government agencies, reimbursement will not exceed the cost of the device.

(5) Selected services in the North Carolina Medicaid Plan are covered and accessible to eligible clients but not listed separately in the state plan. These services include physical, occupational, speech and respiratory therapy as well as services for individuals with speech, hearing or language disorders; and the sites where services are provided include hospital outpatient facilities, physician group practices, home health agencies, public health clinics and area mental health centers as well as the practitioner's office site.

A screening service must document that medically necessary treatment services are needed to correct or ameliorate any defects or chronic conditions found during a screen. The eligible providers referral must be made in accordance with standard of appropriate care developed through consultation with professional societies and public health care agencies. The amount, duration and scope of the services must be reasonably expected to accomplish the referring providers treatment goals in the most economical setting available.

(6) The above listed services are covered as follows:

Other Diagnostic Screening, Preventive and Rehabilitative Services are reimbursed in accordance with Attachment 4.19-B. Clinic services, Hospital Outpatient services, Home Health Agencies and Physician Services are also reimbursed in accordance with Attachment 4.19-B.

The agency assures that if there are providers involved whose payment is based on reasonable cost, the State will provide appropriate cost reimbursement methodologies.

The agency has waived the 6 prescription limit and the 24 visit limit for ambulatory visits for EPSDT eligible clients. The agency will cover all diagnostic and treatment services listed in 1905(a) which are medically necessary to correct or lessen health problems detected during screening. These services will be made available based on individual client needs.

(7) The state assures that EPSDT eligible clients have access to 1905(A) services not specifically listed in the state plan when they are medically necessary. Services provided as described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services and not covered in the state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants.

5. Physicians' Services

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

a. Routine physician examinations and screening tests are covered for adults and EPSDT recipients, which include adults and children in nursing facilities.

b. Experimental - Medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina.

In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts.

b. Eye refractions are limited to one per year for recipients ages 24 and under; and one in two years for recipients ages 25 and over. This limitation was developed on the advice of professional medical consultants and was based on general medical practice. This limitation does not apply to EPSDT eligible children.

c. Prior approval is required for surgical transplants (except bone, tendon, and renal), and cosmetic surgery. Prior approval is required for more than two psychiatric visits.

d. Injections are excluded when oral drugs may be used in lieu of injections.

e. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.

f. Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrist are limited to twenty-four (24) per recipient per State fiscal year. Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

6.a. Podiatrists' Services

(1) Routine foot care is excluded.

(2) Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year. Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

6.b. Optometrists' Services

(1) Refractions are limited to one per year for recipients ages 24 and under; and one in two years for recipients ages 25 and over. This limitation was developed on the advice of professional medical consultants and was based on general medical practice.

(2) Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year.

Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

6.c. Chiropractors' Services

(1) Chiropractic services are limited to manual manipulation of the spine to correct subluxation which has resulted in a neuromusculoskeletal condition for which manipulation is appropriate. Conditions treated must be demonstrated to exist by x-ray taken within 6 months.

(2) Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year. Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

6.d. Other practitioners' services

Limitations for nursing practitioner services are described in Appendix 5 to Attachment 3.1-A.

7. Home Health

Home health services are provided by Medicare certified Home Health Agencies under a plan of care authorized by the patient's physician. Covered home health services include nursing services, services of home health aides, speech therapy, physical therapy, occupational therapy and medical supplies.

a. Intermittent or Part-Time Nursing Services Furnished by a Medicare certified Home Health Agency.

(1) Care which is furnished only to assist the patient in meeting personal care needs is not covered.

(2) Intermittent or part-time nursing service by a registered nurse when no home health agency exists in the area is limited to a registered nurse employed by or under contractual arrangement with a local health department.

b. Home Health Aide Services

Care which is necessary to restore, rehabilitate, or maintain health, including care for the terminally ill, is provided when under professional supervision.

A recipient who elects hospice care waives Medicaid coverage of services by a home health aide under home health services.

c. Medical supplies, equipment, and appliances suitable for use in the home.

(i) Medical Supplies

Medical supplies suitable for use in the home are limited to those items that are medically necessary. These items will be covered when furnished by a Medicare Certified Home Health Agency, DME supplier (for supplies related to DME), PDN provider when providing PDN services (for supplies needed by a Division of Medical Assistance approved PDN patient), or local health department when such health department is providing intermittent or part-time nursing services to the patient as provided in 7.a. above and prescribed by a physician under an approved plan of care.

(ii) Durable Medical Equipment

Medically necessary durable medical equipment (DME) and associated supplies are covered by the Medicaid program when prescribed by a physician and supplied by a qualified DME provider. Prior approval must be obtained from the Division of Medical Assistance, or its designated agent.

To be a qualified provider, an entity must possess a state business license and be certified to participate in Medicare as a DME supplier, or be a Medicaid enrolled home health agency, a state agency, a local health department, a local lead agency for the Community Alternatives Program (CAP) for disabled adults, or for the mentally retarded or developmentally disabled, or a local lead agency that provides case management for the Community Alternative Program for children.

Payment for durable medical equipment is limited to the official, approved DME list established by the Division of Medical Assistance. Additions, deletions or revisions to the DME list are approved by the Director of the Division of Medical Assistance upon recommendation of DMA staff. Only items determined to be medically necessary, effective and efficient are covered.

(iii) Home Infusion Therapy

Self-administered Home Infusion Therapy (HIT) is covered when it is medically necessary and provided through an enrolled HIT agency as prescribed by a physician. "Self-administered" means that the patient and/or an unpaid primary caregiver is capable, able, and willing to administer the therapy following teaching and with monitoring. The following therapies are included in this coverage when self-administered:

a. Total parenteral nutrition

b. Enteral nutrition

c. Intrathecal and intravenous chemotherapy

d. Intravenous antibiotic therapy

e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy

An agency must be a home care agency licensed in North Carolina for the provision of infusion nursing services to qualify for enrollment as a Home Infusion Therapy provider.

In addition to enrolled HIT providers, agencies enrolled to provide durable medical equipment may provide the supplies, equipment, and nutrient solutions/formulae for enteral infusion therapy.